Personal Medical History: Please check and circle if any of the following applies to you. Please write in any condition(s) not listed. If you have none of these conditions, please check none.

None **Yes**

[ ] [ ] **Cardiovascular**: High Blood Pressure, High Cholesterol, Heart Disease
Other: _____

[ ] [ ] **Endocrine**: Diabetes, Thyroid problem, Hormone Dysfunction, Pituitary Disorder
Other: _____

[ ] [ ] **Respiratory**: Asthma, COPD, Emphesema, Bronchititis
Other: _____

[ ] [ ] **Psychiatric**: ADHD,Depression, Anxiety, Bipolar, Schizophrenia
Other:_____

[ ] [ ] **Neurological**: Multiple Sclerosis, Seizures, Headaches Disorder
Other: _____

[ ] [ ] **Musculoskeletal**: Arthritis, Fibromyalgia, Ankylosing Spondylitis
Other: _____

[ ] [ ] **Immunological**: Lupus, Shingles, AIDS or HIV
Other: _____

[ ] [ ] **Constitutional**: Cancer, Developmental Disability
Other: _____

[ ] [ ] **Hematological**: Anemia, Leukemia
Other: _____

[ ] [ ] **Gastrointestinal**: Crohn's, Celiac's, Colitis, Acid Reflux
Other: _____

[ ] [ ] **Ear/Nose/Throat**: Hearing Loss, Sinus Disease, Vertigo, Meniere's
Other: _____

[ ] [ ] **Dermatologic**: Eczema, Rosacea, Psoriasis, Skin Cancer
Other: _____

Family Medical History: Has anyone in your immediate family been diagnosed with:

No **Yes**

[ ] [ ] High Blood Pressure or High Cholesterol
Who: _____

[ ] [ ] Heart or Vascular Disease
Who: _____

[ ] [ ] Diabetes
Who: _____

[ ] [ ] Thyroid problem
Who: _____

[ ] [ ] Multiple Sclerosis
Who: _____

[ ] [ ] Migraines/Headaches Disorder
Who: _____

[ ] [ ] Lupus
Who: _____

[ ] [ ] Shingles
Who: _____

[ ] [ ] Skin Cancer
Who: _____

Today's Date: ____/____/____

Patient Name: _____ **DOB:** _____/_____/_____

When was your last eye exam? _____ Where? _____

Are you using any eye medications today? [ ] Yes [ ] No If Yes, please list _____

Do you currently have prescription eyeglasses? [ ] Yes [ ] No

Do you currently wear contact lenses? [ ] Yes [ ] No [ ] I am interested in contact lenses

Have you ever had an eye injury?
[ ] Yes [ ] No If yes, briefly describe._____

Have you ever had any eye surgeries?
[ ] Yes [ ] No If yes, briefly describe._____

Have you or anyone in your family (grandparents, parents, siblings, children) been diagnosed with:

	Self	*Family Member*		*Self*	*Family Member*
Cataracts:	[ ]	[ ]_____	Retinal Detachment:	[ ]	[ ]_____
Glaucoma:	[ ]	[ ]_____	Lazy Eye or Amblyopia:	[ ]	[ ]_____
Strabismus:	[ ]	[ ]_____	Dry Eyes:	[ ]	[ ]_____
Loss of Vision:	[ ]	[ ]_____	Macular Degeneration:	[ ]	[ ]_____

Any Other Eye Problems? _____

Height: _____ **Weight**: _____
Tobacco Use: [ ] Current [ ] Past [ ] Never
For women, are you currently pregnant or nursing? [ ] Yes [ ] No

Do you have any medication allergies? [ ] Yes [ ] No

If yes, please list: _____
Do you have any environmental allergies, such as pollen? [ ] Yes [ ] No

If yes, please list: _____

Please list any medications, vitamins, or supplements that you are currently taking:
(or ask our staff make a photocopy of your medication list)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Reviewed _____